Issue Briefs:

Massachusetts

Behavioral Health Analysis

Commonwealth of Massachusetts
Department of Public Health

Mental Health Parity and Addiction Equity Act

Changes made by recent federal health care laws are generating a profound change in the behavioral health system. The Mental Health Parity and Addiction Equity Act (MHPAEA), passed in 2008, requires that both fully insured and self-insured large group health plans that cover mental health and substance use disorder benefits do so in a way that is no more restrictive than for physical health (i.e., medical/surgical) benefits. The ACA expanded the application of MHPAEA to plans in the individual and small employer markets and required that these plans provide ten essential health benefits, including mental health and substance use disorder treatment. Because the plans must offer MH and SUD coverage, they must do so at parity with their physical health benefits. In addition, the ACA applied the MHPAEA to Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and State Children's Health Insurance Plans.

Parity means that the financial requirements and non-quantitative treatment limitations for behavioral health services cannot be more restrictive than those for substantially all medical/surgical services.[1] Since behavioral health services do not always correspond to medical/surgical services, understanding how to determine comparability has been complicated. However, the final regulations for MHPAEA, issued in November 2013, have set standards clarifying a number of questions that arose after the interim regulations were issued.

There are six benefit classifications within which plans may not impose a financial requirement or treatment limit restriction for behavioral health services that is more restrictive than the predominant requirement or restriction applicable to substantially all medical/surgical benefits. The benefit classifications are: (1) outpatient in-network services, (2) outpatient out-of-network services, (3) inpatient in-network services, (4) inpatient out-of-network services, (5) emergency care, and (6) prescription drugs.[2] The regulations define predominant as more than half, and substantially all as at least two-thirds. The final regulations allow insurers to define behavioral health services that fall between inpatient and outpatient (e.g., non-hospital residential treatment, partial hospitalization, intensive outpatient) as either inpatient or outpatient, as long as they do so consistently for similar medical/surgical services.[3] In addition, the regulations provide guidance on how to apply these rules. The final regulations also specify that any non-quantitative treatment limitations, including those stemming from medical management standards, prescription formulary design, standards for inclusion in provider networks, and determination of provider rates of reimbursement are subject to MHPAEA. A number of examples of compliant and noncompliant NQTLs are discussed.

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1 Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services. (2011). The mental health parity and addiction equity act. Retrieved from: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html#main_content

2 Departments of the Treasury, Labor, and Health and Human Services. (2013, November 13). Final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act 2008. *Federal Register, 78,* no. 219, accessed from http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf on July 7, 2014.

3 RAND Corporation. (2012). Short-term analysis to support mental health and substance use disorder parity implementation.

State insurance commissioners (the Division of Insurance in Massachusetts) are responsible for enforcement in the group and individual insured health plan markets of their state, [4] and MHPAEA does not supersede states laws that are more stringent. The federal Departments of Labor and Treasury have shared jurisdiction over private, employment-based group health plans, and Health and Human Services (HHS) oversees non-federal governmental plans, such as those sponsored by state and local government employers.

Within Massachusetts, regulations require insurance carriers to assess their compliance with state[5] and federal parity laws and regulations annually and submit a certificate of compliance to the Division of Insurance[6] and the Attorney General.[7] Medicaid contracted managed care plans must review their administrative and other practices and submit a report on their review and to either certify that their plans fully comply with the federal and state mental health parity laws, or identify areas of non-compliance and a corrective action plan to bring those practices into compliance (Add footnote to 130 CMR 450.117(J)).

Research on the impact of the implementation of parity requirements has generally not found an increase in expenditures. One review found that the implementation of parity requirements was associated with reduced expenditures in six out of nine studies.[8] A separate study examining the effects of parity on expenditures for behavioral health services in Oregon suggests that parity does not substantially influence total costs.[9] Overall, evidence indicates that parity will not dramatically increase enrollee expenditures. It is still unclear what effect parity will have on access to and utilization of behavioral health care; in a review of 17 studies examining the effect of coverage on access to or use of behavioral health services, findings were mixed.[10]

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[4] Weber, E. (2013). Equality standards for health insurance coverage: Will the Mental Health Parity and Addiction Equity Act end the discrimination? *Golden Gate University Law Review, 43*, 179-257.

[5] Chapter 256 of the Acts of 2008, An Act Relative to Mental Health Parity accessed from https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter256 on July 7, 2014.

[6] 211 CMR 15 4.00: Enforcement of Mental Health Parity accessed from http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-154-proposed.pdf on July 7, 2014.

[7] Chapter 224 An act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation. Section 254, accessed from https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224 on July 7, 2014.